Adult Female Networked Health Information

Last Update:_____

Patient First Name:_____ M. Init:___ Last Name:_____ PartnerName:_____

Billing Address:_____ Soc. Sec. No.: ___ ___ _____ Primary Physician: _____

City:_____ State:_____ Day Phone: (___) _____-_____ Referred by: _____

Zip:_____ Eve. Phone: (___) _____-_____ Occupation:_____

Date of birth: ____/___/_____ Age: _____ Status: S[ ] M[ ] W[ ] Sep[ ]

MEDICAL HISTORY

Please check appropriate box. Enter [✓] if you or a close family member have had any of the following illnesses.:

You	Family	Medical illnesses:
[ ]		Use of alcohol or smoking
[ ]	[ ]	Allergies or asthma
[ ]	[ ]	Anemia or bleeding problems
[ ]	[ ]	Diseases of bones
[ ]	[ ]	Cancer or tumors
[ ]	[ ]	Heart problems
[ ]	[ ]	Excess bleeding from cuts
[ ]	[ ]	Diabetes
[ ]		Use drugs (other than medications)
[ ]		Ear, nose and throat problems
[ ]	[ ]	Diseases of the glands
[ ]		Intestinal or stomach problems
[ ]	[ ]	Inherited diseases
[ ]		Gynecological problems
[ ]		Hemorrhoids
[ ]		Liver problem
[ ]		Hernias
[ ]	[ ]	High blood pressure
[ ]	[ ]	Infectious diseases (e.g. TB)
[ ]		Migraines or severe headaches
[ ]		Kidney or bladder problems
[ ]		Respiratory or lung diseases
[ ]		Toxoplasmosis, German measles, virus exposure or herpes
[ ]		Venereal diseases

Enter [✓] into the correct response

Yes	No	Have you had surgery of
[ ]	[ ]	Head, eyes, ears, nose or throat?
[ ]	[ ]	Breasts?
[ ]	[ ]	Chest or heart?
[ ]	[ ]	Gall bladder or abdominal organs?
[ ]	[ ]	Uterus, tubes, ovaries or vagina?
[ ]	[ ]	Kidney or bladder

Please list other surgery below.

_____

_____

_____

_____

Yes	No	Any allergies to:
[ ]	[ ]	Penicillin?
[ ]	[ ]	Sulfas?
[ ]	[ ]	Aspirin?
[ ]	[ ]	Narcotics?

Please list other drug allergies below.

_____

_____

_____

_____

Current method of contraception: None[ ] Pill[ ] IUD[ ] Diaph[ ] Other _____

List other health problems that you are concerned about below:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Menstrual History

First period at the age of: _____

Menstrual flow lasts: _____days

Cycle length: _____days

Period is: Regular [ ] Irregular [ ]

Pain is: Mild [ ] Mod [ ] Severe [ ]

Start date of last period: ____/___/_____

Year of menopause (if applicable): ____

Total number of pregnancies? ____

No. of full term births? ____

No. of premature births? ____

No. of abortions/miscarriages? ____

No. of living children? ____

List medications that you are currently taking: (Bring medications with you)

1. _____ Dose: _____
2. _____ Dose: _____
3. _____ Dose: _____
4. _____ Dose: _____
5. _____ Dose: _____

Please use the other side for detailed explanations of illnesses or hospitalizations.